IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 3, 2010

Rene Stephens, Administrator
Hillcrest Home
1411 Falls Avenue East Suite 703
Twin Falls, Idaho 83301

RE: Hillcrest Home, Provider #13G048

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Hillcrest Home, on January 26, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 16, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

TOM MROZ, CFI-II
Health Facility Surveyor
Fire Life Safety & Construction Program

TM/lj

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G048	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	01/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST GROUP HOME	2115 HILLCREST DRIVE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a residential single story, Type V(000) building. It was built in 1992 and is fully sprinklered in living spaces and closets. There is a complete fire alarm/smoke detection system. Currently the facility is licensed for 6 ICF/MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on January 26, 2010., under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability and 42 CFR 483.470 (j). The Survey was conducted by: Tom Mroz CFI-II Health Facility Surveyor Facility Fire/Life Safety and Construction Program	K 000		
K0029	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Any hazardous area that is on the same floor as, and is in or abuts, a primary means of escape or a sleeping room is protected by one of the following means: (a) Protection is an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than ¾ hour. (b) Protection is automatic sprinkler protection, in	K0029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene Stephens — TITLE: Administration — (X6) DATE: 3/2/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0029	Continued From page 1 accordance with 32.2.3.5, and a smoke partition, in accordance with 8.2.4, located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation is self-closing or automatic closing in accordance with 7.2.1.8. 33.2.3.2.2. This Standard is not met as evidenced by: Based on observation, the facility failed to ensure that transfilling of liquid oxygen be accomplished at a location meeting the requirements for transfilling oxygen. The deficient practice would affect all residents, staff and visitors in the facility. The facility has the capacity for 6 licensed beds with a census of 6 on the day of the survey. Findings include: During observation on January 26, 2010 at 2:30 P.M., disclosed the oxygen transfilling enclosure in the garage was not mechanically ventilated, did not contain a fire sprinkler and the door did not contain a self closure device. Required signage was not in place. The finding was observed by the Administrator and the surveyor. Actual NFPA standard: NFPA 99 §8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) Separated from any portion of a facility	K0029	K0029 – Oxygen transfilling is now being done on a concrete slab on the back patio away from the facility. It is not enclosed and signs are posted that no smoking is permitted in the immediate area. The building inspection now includes a monthly check to be sure this item stays in compliance. Date of compliance: 3/2/2010 Responsible: Facility Manager and Administrator	

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K0029	Continued From page 2 wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and (c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K0029		

Bureau of Facility Standards

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M 000	16.03.11 Inital Comments The facility is a residential single story, Type V(000) building. It was built in 1992 and is fully sprinklered in living spaces and closets. There is a complete fire alarm/smoke detection system. Currently the facility is licensed for 6 ICF/MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on January 26, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability, 42 CFR 483.470 (j) and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF-MR). The Survey was conducted by: Tom Mroz CFI- II Health Facility Surveyor Facility Fire/Life Safety and Construction Program	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal CMS K tag K029 relating to hazardous areas.	MM309	See K0029	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Irene K Stephens — TITLE: Administration — (X6) DATE: 3/2/2010